



American College of Osteopathic Family Physicians

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New Physicians & Residents Program— Medical Insurance Logistics and Evolution

Friday, 3/19/2010

9:00-11:00 am

Eric J. Berman, DO, MS

The American College of Osteopathic Family Physicians is accredited by the American Osteopathic Association Council to sponsor continuing medical education for osteopathic physicians.

The American College of Osteopathic Family Physicians has requested that the AOA Council on Continuing Medical Education approve this program for AOA Category 1A CME Credit. Approval is pending.



New Physician and Resident's Program

Medical Insurance Logistics and Evolution

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3/19/2010

A Brief History of U.S. Health Insurance and Health Reform Efforts

- Mid to Late 1800's
 - 1861-65 (Civil War)
 - The first insurance plans began with the earliest policies offering coverage against accidents related from travel by rail or steamboat.
 - Paved the way for more comprehensive plans covering all illnesses and injuries.
 - The first group policy giving comprehensive benefits was offered by Massachusetts Health Insurance of Boston in 1847.
 - Insurance companies issued the first individual disability and illness policies in about 1890.

A Brief History of U.S. Health Insurance and Health Reform Efforts

- Early 1900's
 - 1912
 - Teddy Roosevelt and his Progressive party endorse social insurance as part of their platform, including health insurance. National Convention of Insurance Commissioners develops first model of state law for regulating health insurance.
 - 1915
 - The American Association for Labor Legislation (AALL) publishes a draft bill for compulsory health insurance. A few states show interest, but fail to enact as U.S. enters into World War I.
 - 1920
 - Given the rudimentary state of medical technology prior to 1920, most people had very low medical expenditures. The chief cost associated with illness was that sick people couldn't work and didn't get paid. A 1919 State of Illinois study reported that lost wages due to sickness were 4x larger than treatment costs.
 - Most people felt they didn't need health insurance and purchased "sickness" insurance similar to today's "disability" insurance to provide income replacement in the event of illness.
 - Low demand was matched by commercial insurance companies unwillingness to offer private health insurance policies due to the high potential for adverse selection (sick people claiming to be healthy) and moral hazard (adverse changes in behavior).
 - By 1920, many European nations had adopted some form of compulsory, nationalized insurance.

A Brief History of U.S. Health Insurance and Health Reform Efforts

- Early 1900's continued
 - 1920-30
 - Rise in the price of medical care due to;
 - Shifting treatment of acute illness from homes to hospitals to accommodate the population shift from rural areas to urban centers
 - Improved quality standards for physicians and hospitals coupled with advances in medical technology and growing acceptance of medicine as a science
 - 1921
 - Women reformers persuade Congress to pass the Sheppard-Towner Act providing matching funds to states for prenatal and child health centers. Act expires in 1929 and is not reauthorized.
 - 1927
 - Committee on the Costs of Medical Care forms to study the economic organization of medical care. Comprised of economists, physicians, public health specialists, and other major interest groups their recommendations include medical group practice and voluntary health insurance.
 - 1929
 - Baylor Hospital introduces a pre-paid hospital insurance plan for a group of school teachers (considered the forerunner of future nonprofit Blue Cross plans).
 - The Great Depression spans a decade (1929-39), with 1933-34 being the worst years.

A Brief History of U.S. Health Insurance and Health Reform Efforts

- 1930-34
 - Hard economic times called for social policies to secure employment, retirement, and medical care. President Roosevelt appointed a committee to work on all these issues, but in the end did not risk the passage of the Social Security Act to advance national health reform in the form of universal health care coverage.
 - Pre-paid hospital service plans were grew during the Great Depression and were mutually advantageous to consumers and hospitals suffering from falling incomes in the early 1930's. Supported by the American Hospital Association (AHA) prepayment provided a constant stream of income to hospitals. Single-hospital plans increased competition among hospitals.
 - Under the auspices of the AHA, community hospitals organized to offer hospital coverage and reduce inter-hospital competition under the name Blue Cross (BC). Due to enabling legislation the BC designation permitted:
 - Free choice of physicians and hospitals
 - Elimination of single-hospital plans
 - Non-profit corporate structure hence tax-exempt status and regulatory relief from the reserve requirements demanded of commercial insurance companies since the Blues were underwritten by hospitals and felt to be in society's best interest
- 1935-39
 - President Roosevelt continued to support national health reform throughout his terms. His second push for national health insurance came after the Social Security Act passed. However, the momentum from FDR's Technical Committee on Medical Care and a National Health Conference could not overcome a Congress no longer supportive of further government expansion.

A Brief History of U.S. Health Insurance and Health Reform Efforts

- 1935
 - Committee on Economic Security (est. in 1934 by FDR) issues final recommendations. None explicitly address national health insurance but principles of health reform are outlined. Committee later issues unpublished report "Risks to Economic Security Arising Out of Illness."
 - Social Security Act passed by Congress. The Act includes grants for Maternal and Child Health which restored many of the programs established under the Sheppard-Towner Act and extended the role of the Children's Bureau to include maternal and child health services as well as other child welfare services.
- 1939
 - Physicians start to organize the first pre-paid, Blue Shield (BS) plans, to cover the costs of physician care.
 - Like BC, through enabling legislation BS plans received:
 - Non-profit, tax-exempt status
 - Freedom from provisions of insurance statutes
 - California Physicians' Service (CPS) began operation as the first prepayment plan designed to cover physicians' services and was offered to employee groups.
 - Department of Health and Human Services was born as the Federal Security Agency bringing together federal agencies concerned with health, welfare, and social insurance.

A Brief History of U.S. Health Insurance and Health Reform Efforts

- 1940-45
 - 1940
 - Growth in the health insurance market continued due to increased supply, once commercial insurers entered and demand, as medical technology advanced and government policies encouraged health insurance as a form of employee compensation
 - 1942
 - Federal Government attempts to control inflation in the overheated wartime economy by limiting employers' freedom to raise wages and thus compete for scarce workers based on pay.
 - 1943
 - War Labor Board rules wage freeze does not apply to fringe benefits, including health insurance benefits.
 - Senators Wagner and Murray, along with Representative Dingell introduce legislation as part of broader vision to operate health insurance as part of social security. Wagner-Murray-Dingell bill includes provisions for universal comprehensive health insurance along with other changes to social security meant to move toward system of "cradle to grave" social insurance.
 - 1944
 - FDR outlines 'economic bill of rights' including right to adequate medical care and the opportunity to achieve and enjoy good health in his State of the Union address.
 - Social Security Board calls for compulsory national health insurance as part of the Social Security system.

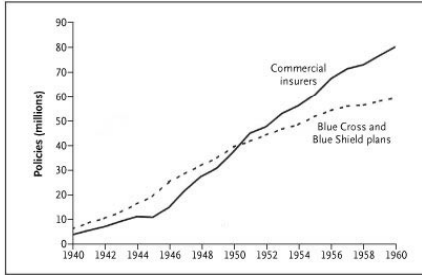
A Brief History of U.S. Health Insurance and Health Reform Efforts

- 1945-49
 - President Truman picked up the mantle for a national health program just months after the end of World War II. His election in 1948 appeared to be a mandate for national health insurance, but the opposition, using fear of socialism, coupled with the power of southern Democrats who believed a federal role in health care might require desegregation, effectively blocked all proposals.
 - 1946
 - AMA encourages state and local medical societies to establish their own prepayment plans that were affiliated and ultimately known as BS
 - Most plans offered medical and surgical benefits to hospitalized members
 - Some covered office visits, some low-income subscribers (plans directly reimbursed physicians for services), most were mixed service-indemnity plans (doctors charged subscribers the difference between their actual charges and what BS reimbursed thereby retaining price discrimination (option to charge customers based on their ability to pay)
 - 1948
 - National Health Assembly convened in Washington, D.C. by the Federal Security Agency. Final report endorses voluntary health insurance, but reiterated need for universal coverage
 - AMA launches a national campaign against national health insurance proposals
 - 1949
 - Supreme Court upholds National Labor Relations Board ruling that employee benefits can be included in collective bargaining

A Brief History of U.S. Health Insurance and Health Reform Efforts

- 1954
 - President Eisenhower proposes a federal reinsurance fund to enable private insurers to broaden the groups of people they would cover.
- 1956
 - Military "medicare" program enacted, providing government health insurance for dependents of those in the Armed Forces.
- 1960-64
 - The success of BC and BS demonstrated how adverse selection could be avoided by insuring young, healthy groups of employed workers who did not individually seek health insurance.
 - The groundwork for the enactment of Medicare and Medicaid began in the late 1950s and early 1960s. As employer-based health coverage grew, private plans began to set premiums based on their experience with health costs and the retired and disabled found it harder to get affordable coverage. Health reformers refocused their efforts toward the elderly.
 - Civil Rights Act passes.

Enrollment in Private Health Insurance in the U.S. 1940 - 1960



Enrollment in Private Health Insurance in the U.S. 1940 - 1960

Commercial v Blues (Community Rating v Experience Rating)

- Success of the commercial companies was aided by two factors
 - By virtue of their non-profit status, the Blues were required to utilize community rating of their policies (i.e. same premium for all members regardless of health status)
 - For-profit commercial plans could utilize a group's experience to rate policies (i.e. premium tied to health status)
 - This resulted in commercial plans offering healthy groups lower premiums than the Blues and gaining market share

A Brief History of U.S. Health Insurance and Health Reform Efforts

- 1965-69
 - Medicare and Medicaid were incorporated under the Social Security Act and signed by President Johnson in 1965 with Truman by his side. The combination of Johnson's political skills, a large Congressional Democratic majority, public approval, the support of the hospital and insurance industries, and the fact that no government cost controls or physician fee schedules were enacted contributed to the passage of the most significant health reform of the century.
 - 1965
 - The Medicare and Medicaid programs are signed into law. Medicare Part A is to pay for hospital care and limited skilled nursing and home health care. Optional Medicare Part B is to help pay for physician care. Medicaid is a separate program to assist states in covering not only long-term care for the poor but also to provide health insurance coverage for certain classes of the poor and disabled.
 - Neighborhood health centers (precursors to Federally Qualified Health Centers or FQHCs) are established as part of the Office on Economic Opportunity to provide health and social services to poor and medically underserved communities.
 - 1967
 - Social Security amendments pass, adding optional Medicaid categories to insure others who are not receiving cash assistance. Early and Periodic Screening and Diagnostic Testing (EPSDT) benefits are also added to Medicaid.

A Brief History of U.S. Health Insurance and Health Reform Efforts

- 1970-74
 - General inflation and unchecked health care costs were a growing concern by the early 1970s. Sen. Kennedy's proposal for national health insurance was countered by President Nixon's own Comprehensive Health Insurance Plan (CHIP).
 - 1971
 - Wage and price freezes begin, with medical care singled out for specific limits on annual increases in physician and hospital charges. Medical care limits are not lifted until 1974, over a year after other controls had ended.
 - 1972
 - Supplemental Security Income (SSI) program begins providing cash assistance to elderly and disabled.
 - Social Security amendments pass allowing people under age 65 with long-term disabilities and end stage renal disease (ESRD) to qualify for Medicare coverage. Those with long-term disabilities must wait for two years before qualifying for Medicare.

A Brief History of U.S. Health Insurance and Health Reform Efforts

- 1975-79
 - In the face of stagflation and rapidly rising health care costs, President Carter prioritizes health care cost containment over expanding coverage. Sen. Kennedy, however, drafts another national health insurance proposal, which is then followed by Carter's own plan that would delay implementation until 1983. National health reform efforts were completely stalled in the face of an economic recession and uncontrollable health care costs.
 - 1977
 - Health Care Financing Administration (HCFA) established within Department of Health, Education, and Welfare (HEW).

A Brief History of U.S. Health Insurance and Health Reform Efforts

- 1980-84
 - 1980
 - Department of Health, Education, and Welfare renamed the Department of Health and Human Services (DHHS).
 - During the 1980's and 1990's the cost of health care rises rapidly. The majority of employer-sponsored group plans switch from FFS to cheaper managed care plans with this being the dominant option by the mid-1990's
 - 1981
 - Federal budget reconciliation (OBRA 81) requires states to make additional Medicaid payments to hospitals who serve a disproportionate share of Medicaid and low-income patients. It also repeals the requirement that state Medicaid programs pay hospital rates equivalent to those paid by the Medicare program. Requires states to pay nursing homes at rates that are "reasonable and adequate" under the Boren Amendment (applied to hospitals the following year).
 - Two types of Medicaid waivers are established under a budget reconciliation act (OBRA 81) allowing states to mandate managed care enrollment of certain Medicaid groups and to cover home and community-based long-term care for those at risk of being institutionalized.
 - 1982
 - States allowed to expand Medicaid to children with disabilities who require institutional care but can be cared for at home and would not otherwise qualify for Medicaid if not institutionalized; popularly referred to as the Katie Beckett option for the disabled child who garnered national attention on the issue.

A Brief History of U.S. Health Insurance and Health Reform Efforts

- 1983
 - Medicare introduces Diagnostic Related Groups (DRGs) as a prospective payment system for hospital payment.
- 1985-89
 - 1986
 - Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals participating in Medicare to screen and stabilize all persons who use their emergency rooms regardless of ability to pay.
 - COBRA (Consolidated Omnibus Budget Reconciliation Act) contains specific regulations that allow employees who lose their jobs to continue with their health plan for 18 months.
 - Federal budget reconciliation (OBRA 86) gives states Medicaid option to cover infants, young children and pregnant women up to 100% of the poverty level regardless of whether they receive public assistance. Raised to 185% of the poverty level in legislation for infants and pregnant women the following year. OBRA 86 also allowed state Medicaid programs to pay Medicare premiums and cost sharing for qualified Medicare beneficiaries (QMBs) under 100% of poverty. This was later required in 1989 and increased to certain Medicaid beneficiaries at 120% of poverty in 1990.

A Brief History of U.S. Health Insurance and Health Reform Efforts

- 1987
 - Census Bureau begins annual estimate of health insurance coverage in the United States with its Current Population Survey finds 31 million uninsured (13% of the population) in 1987.
- 1988
 - Medicare Catastrophic Coverage Act (MCCA) expands Medicare coverage to include prescription drugs and a cap on out-of-pocket expenses. Concern that costs to elderly would outweigh benefits causes these provisions to be repealed. States were still required to pay Medicare premiums and cost-sharing amounts for poor beneficiaries through Medicaid is maintained.
 - The Family Support Act requires states to extend 12 months of transitional Medicaid coverage to families leaving welfare due to earnings from work.
- 1989
 - Federal budget reconciliation (OBRA 89) mandates coverage for pregnant women and children under age 6, at 133% of the federal poverty level.

A Brief History of U.S. Health Insurance and Health Reform Efforts

- 1990-94
 - Making national health reform a priority early in his Presidency, Clinton proposed a "managed competition" approach, sending a detailed plan to Congress in 1993. It called for universal coverage, employer and individual mandates, competition between insurers, with government regulation to control costs. Support from key stakeholders was often limited and conditional. The opposition was led largely by two groups: the Health Insurance Association of America and the National Federation of Independent Businesses, both believing reform would create hardship for their smaller members. Congressional Democrats were divided in their support, and further splintered by a variety of alternative proposals that were then generated, all of which blocked progress on the President's plan.
- 1990
 - Federal budget reconciliation (OBRA 90) legislation mandates Medicaid coverage of children age 6-18 under poverty level, phased in one year at a time until 2002.
 - National Committee on Quality Assurance (NCQA) forms to accredit managed care health plans.

A Brief History of U.S. Health Insurance and Health Reform Efforts

- 1993
 - Within his first week in office President Clinton convenes White House Task Force on Health Reform, and appoints First Lady Hillary Clinton as chair.
 - President Clinton's proposal, named the Health Security Act, is introduced in both houses of Congress in November, but gains little support. Every American would have a "Health Security Card" to ensure access to care.
 - The Clinton Administration begins approving Medicaid waivers allowing more statewide expansion demonstrations. Many states turned to managed care for delivery of services and used savings to expand to previously uninsured groups.
 - Vaccines for Childrens (VFC) providing federally purchased vaccines to states is established.
 - Other national health reform proposals are introduced in Congress, but also fail to garner sufficient support for passage - the McDermott/Wellstone single payer health insurance proposal and Cooper's proposal for managed competition without a guarantee of universal coverage. By mid-1994 even a bipartisan bill to expand coverage without comprehensive reform is unable to pass.

A Brief History of U.S. Health Insurance and Health Reform Efforts

- 1995-1999
 - 1996
 - Health Insurance Portability and Accountability Act (HIPAA) restricts use of pre-existing conditions in health insurance coverage determinations, sets standards for medical records privacy, and establishes tax-favored treatment of long-term care insurance.
 - Mental Health Parity Act enacted that prohibits group health plans from having lower annual or lifetime dollar limits for mental health benefits than medical or surgical benefits (except substance abuse and chemical dependency).
 - 1997
 - Census Bureau's Current Population Survey estimates 42.4 million (15.7% of the population) uninsured in the United States.
 - Balanced Budget Act (BBA) includes many changes in provider payments to slow the growth in Medicare spending. It establishes the Medicare-Choice program, a new structure for Medicare HMOs and other private plans offered to beneficiaries, later re-named Medicare Advantage in 2003.
 - Also part of the Balanced Budget Act, the State Children's Health Insurance Program (SCHIP) is enacted. Provides block grants to states allowing for coverage of low-income children above Medicaid eligibility levels. BBA also allows states to cover working disabled with incomes up to 250% of poverty, permits mandatory Medicaid enrollment in managed care and repeals the Boren amendment.
 - 1999
 - Ticket to Work and Work Incentives Improvement Act of 1999 allows states to cover working disabled with incomes above 250% of poverty and impose income-related premiums.

A Brief History of U.S. Health Insurance and Health Reform Efforts

- 2000-2004
 - 2000
 - Breast and Cervical Cancer Treatment and Prevention Act of 2000 allows states to provide Medicaid coverage to uninsured women for treatment of breast or cervical cancer if they have been diagnosed through a CDC screening program, regardless of income or resources.
 - 2002
 - President Bush launches Health Center Growth Initiative significantly expanding the number of community health centers serving the medically underserved.
 - 2003
 - Maine passes the Dirigo Health Reform Act, a comprehensive health care reform plan, that creates the DirigoChoice health plan, providing subsidized coverage to individuals and small employers, expands Medicaid, and creates the Maine Quality Forum.
 - Medicare Drug, Improvement, and Modernization Act (MMA) passes, creating a voluntary, subsidized prescription drug benefit under Medicare, administered exclusively through private plans, both stand-alone prescription drug plans and Medicare Advantage plans.
 - Medicare legislation creates Health Savings Accounts which allow individuals to set aside pre-tax dollars to pay for current and future medical expenses. The plans must be used in conjunction with a high deductible health plan.

A Brief History of U.S. Health Insurance and Health Reform Efforts

- 2005-2009
 - 2005
 - Deficit Reduction Act of 2005 makes significant changes to Medicaid related to premiums and cost sharing, benefits, and asset transfers.
 - 2006
 - Medicare Part D Drug benefit goes into effect in January.
 - Massachusetts passes and implements legislation to provide health care coverage to nearly all state residents. Legislation requires residents to obtain health insurance coverage and calls for shared responsibility among individuals, employers, and the government in financing the expanded coverage. Within two years of implementation the state's uninsured rate is cut in half.
 - One month following Massachusetts, Vermont passes comprehensive health care reform also aiming for near-universal coverage. In addition to creating the Catamount Health Plan for uninsured residents, the plan focuses on improving overall quality of care and the management of chronic conditions through the Blueprint for Health.
 - City of San Francisco creates the Healthy San Francisco program, providing universal access to health services in the city for residents. A controversial provision requiring city employers to spend a minimum amount per hour on healthcare for their employees is challenged in court. In September 2006, the U.S. Ninth Circuit Court of Appeals upholds the employer requirement saying it does not violate the Employee Retirement and Income Security Act of 1974 (ERISA).

A Brief History of U.S. Health Insurance and Health Reform Efforts

- 2007
 - Senators Wyden and Bennett introduce the Healthy Americans Act. Proposal would require individuals to obtain private health insurance coverage through state health insurance purchasing pools. The long-standing favorable tax treatment of employer-sponsored insurance premiums would be eliminated. Legislation gains some bipartisan support.
 - Census Bureau estimates 45.6 million uninsured (15.3% of the population) in 2007. Survey instrument undergoes periodic design improvements over the years that confound trend analyses, yet remains the most widely used estimate of health insurance coverage.
 - President Bush announces health reform plan that would replace the current tax preference for employer-sponsored insurance with a standard health care deduction. Proposal is not acted upon by Congress.
 - Congress passes two versions of a bill to reauthorize the State Children's Health Insurance Program with bi-partisan support, but President Bush vetoes both bills and Congress cannot override the veto. A temporary extension of the program is passed in December 2007.
 - California fails in its attempt to pass a health reform plan with an individual mandate and shared responsibility for financing the costs. Compromise legislation supported by the Governor passes the Assembly, but falls short in the Senate.

A Brief History of U.S. Health Insurance and Health Reform Efforts

- 2008
 - Mental Health Parity Act amended to require full parity. Insurance companies must treat mental health conditions, including substance abuse disorders, on an equal basis with physical conditions when health policies cover both.
 - Presidential campaign focuses early on national health reform, overshadowed later by housing crisis and economic downturn, yet remains a key pocketbook issue throughout the campaign. Both major party candidates announce comprehensive health reform proposals.
 - Sen. Baucus, Chairman of the Senate Finance Committee, releases White Paper on health reform outlining a national health reform plan based on the Massachusetts model.

A Brief History of U.S. Health Insurance and Health Reform Efforts

- 2009
 - President Obama establishes Office of Health Reform to coordinate administrative efforts on national health reform.
 - The Children's Health Insurance Program (CHIP) is reauthorized, providing states with additional funding, new tools and fiscal incentives to help reach and estimated 4.1 million children through Medicaid and CHIP who otherwise would have been uninsured by 2013.
 - The American Reinvestment and Recovery Act (ARRA) makes substantial investments to help develop health information technology, expand the primary care workforce and conduct research on comparative effectiveness for health care treatment options.
 - White House holds a Health Reform Summit with key stakeholders.
 - President Obama releases FY 2010 budget which outlines eight principles for health reform and proposes a set aside of 634 billion in a health reform reserve fund.
- 2010
 - Congress continues to deliberate national health reform options.

Pulse Check

- Who has coverage and how are they covered?
- What is the impact of chronic medical conditions?
- How are we performing in health care as a nation?
 - On cost?
 - On quality?
 - On other outcome measures?

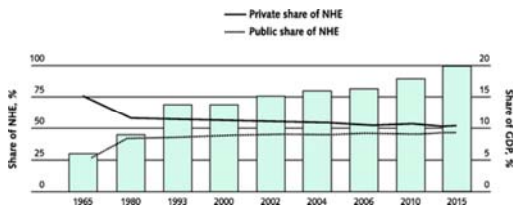
Who's Covered and How?

- 250 M Americans (84.2%) have some form of health coverage
- 47 M Americans (15.8%) were uninsured for a year as reported for 2006 by the U.S. Bureau of the Census
- 43.6 M Americans (14.8%) of all ages were uninsured at the time of the National Health Expenditure Survey interview in 2006 as reported by a Center for Disease Control and Prevention survey
- As many as 89.5 M Americans under the age of 65 lacked health insurance for at least 1 month during 2006-2007 according to a study by Lewin and associates
- Another 16 M Americans can be considered underinsured
- In total, 63 M Americans are either un- or underinsured

Who's Covered and How?

- Employer-based health insurance covered 59.7% of the U.S. population in 2006, down from 63.6% in 2000
- Government programs covered 46% of all U.S. health care costs through public programs
 - Medicare accounted for 17% [42.5 M Americans (35.6 M qualified due to age based eligibility and 6.7 M because of disability including ESRD)]
 - Medicaid & State Children's Health Insurance Plan (CHIP) accounted for 16% [52 M Americans including 25% of U.S. children (21 M) and supplements Medicare coverage for 7 M elderly and disabled – Note – 70% of expenditures are for elderly (25%) and disabled adults (45%)]
 - Other Public Programs account for 13% (Veterans Health Administration, Department of Defense, workers' compensation, and public health)

U.S. national health expenditure (NHE) as a share of gross domestic product (GDP) and private and public shares of NHE



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What is the Impact of Chronic Medical Conditions?

- 45% of the U.S. population (60 M people) have 1 chronic medical condition
- 50% of these individuals have multiple chronic conditions
- 83% of Medicare beneficiaries have 1 or more chronic medical conditions
- 23% of Medicare beneficiaries have 5 or more chronic medical conditions
- By 2015, an estimated 150 M Americans will have at least 1 chronic medical condition

How Does the U.S. Health Care System Compare to the Rest of the Industrialized World?

Percentage of GDP and Per Capita Spending on Health Care A Selected International Comparison

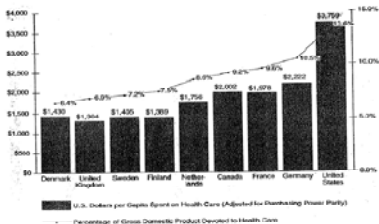


Figure 1-1 Selected International Comparisons of the Percentage of Gross Domestic Product and Per Capita Spending on Health Care in 1996. Source: Adapted with permission from G.F. Anderson, in *Selected Values, Health Affairs*, Vol. 16, No. 2, p. 164, Copyright © 1997, The People-to-People Health Foundation, Inc., all rights reserved; and K.K. Levi et al., *National Health Spending Trends in 1996*, *Health Affairs*, Vol. 17, No. 1, p. 29, Copyright © 1998, The People-to-People Health Foundation, Inc., all rights reserved.

Three Health Care Outcome Measures A Selected International Comparison

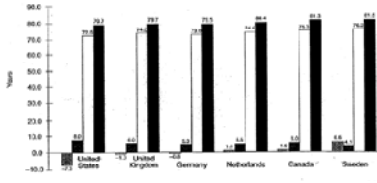


Figure 1-2 Selected International Comparisons on Three Health Care Outcome Measures in 1995. Source: Adapted with permission from G.F. Anderson, in *Selected Values: An International Comparison of Cost, Access, and Outcomes, Health Affairs*, Vol. 16, No. 6, p. 170, Copyright © 1997, The People-to-People Health Foundation, Inc., all rights reserved.

U.S. Scores on 6 Categories of System Performance

- The U.S. composite scores for each of the 6 categories are listed after each category:
 - Long, healthy, and productive lives: 69
 - Quality: 71
 - Access: 67
 - Efficiency: 51
 - Equity: 71
 - Capacity to innovate and improve: not scored.

Commonwealth Fund Overall Rankings of 6 Countries According to Key Indicators of Performance

Country Rankings
 1.00-2.66
 2.67-4.33
 4.34-6.00

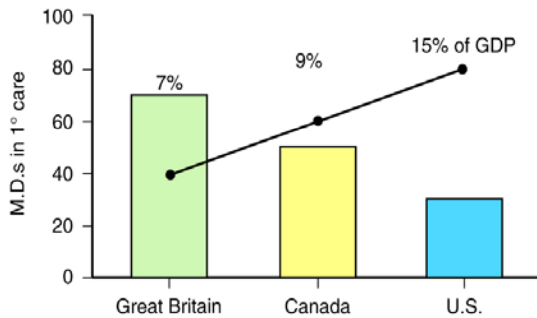
	Australia	Canada	Germany	New Zealand	United Kingdom	United States
Overall Ranking (2007)	3.5	5	2	3.5	1	6
Quality Care	4	6	2.5	2.5	1	5
Right Care	5	6	3	4	2	1
Safe Care	4	5	1	3	2	6
Coordinated Care	3	6	4	2	1	5
Patient-Centered Care	3	6	2	1	4	5
Access	3	5	1	2	4	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Healthy Lives	1	3	2	4.5	4.5	6
Health Expenditures per Capita, 2004	\$2876*	\$3165	\$3005*	\$2083	\$2546	\$6102

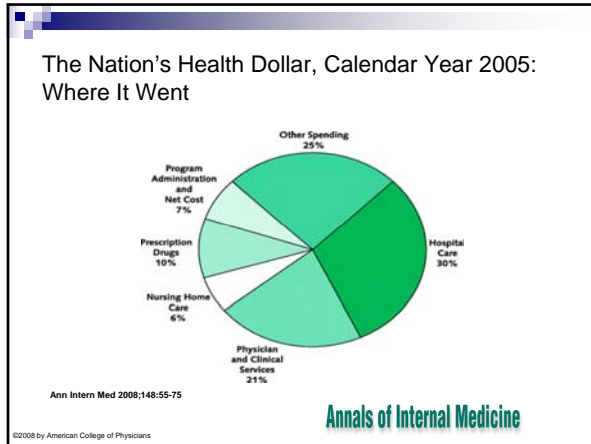
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Annals of Internal Medicine

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INVERSE RELATIONSHIP BETWEEN PERCENT OF PRIMARY CARE PHYSICIANS AND COST OF HEALTH CARE





The Nation's Health Dollar, Calendar Year 2005:
Where It Went

- "Physician and Clinical Services" includes offices of physicians, outpatient care centers, and medical and diagnostic laboratories.
- "Other Spending" includes dentist services, other professional services, home health, durable medical products, over-the-counter medicines and sundries, public health, other personal health care, research, and structures and equipment

Recap and Review of Some Medical Cost Drivers

- In-patient and Out-patient care ~ 30-40% of our total spend (~ \$800B - \$1T)
- Chronic conditions
 - In every age group in the U.S. approximately 10% of the population incurs 60-70% of the costs
 - Obesity (direct and indirect costs) estimated between \$174 - \$800B/year. Has the trend reached a plateau?
 - Smoking related deaths in the U.S. ~ 443,000/year
- Imaging costs > \$100B/year and rising

Total Imaging Market Trends

*AHIP, Ensuring Quality Through Appropriate Use of Diagnostic Imaging, July 2008

- U.S. imaging market size is estimated at \$100 B
- Growing at 18-20% per year for most health plans
 - By comparison pharmacy costs are growing at 6-8% per year
 - Expenditures are expected to double within 4 years
 - Rapidly approaching 10% of total health care costs

Imaging Market: 2008 Est. Costs by Modality in Billion Dollars

Specialty Healthcare Services: IDTF/Imaging Sector: Deutsche Bank October 19, 2007

- CT/PET* = \$29.5
- X-Ray/Mammography = \$22.1
- Nuclear Medicine* = \$19.0
- MRI* = \$15.2
- Ultrasound = \$13.3
- Other = \$2.7
- Total/Subtotal* = \$101.8/\$63.7*

*Denotes services commonly requiring prior authorization

U.S. Advanced Imaging Utilization MRI Units/M persons in 2006*

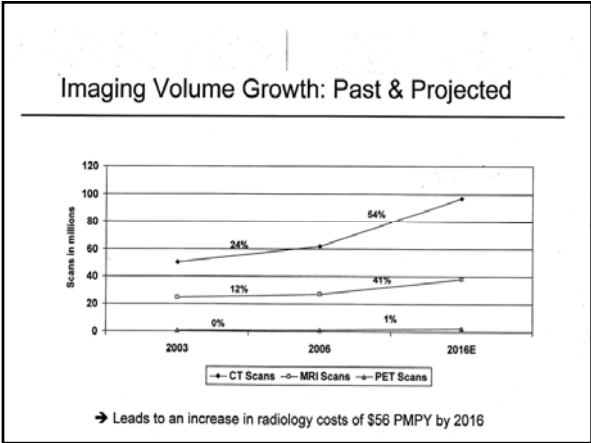
Organization for Economic Cooperation and Development (OECD) Health Data 2008*

- U.S. = \$26.5 (Highest spend by nearly 2-5x)
- Switzerland = \$14
- Germany = \$7.7 (also OECD Median value)
- Netherlands (2005) = \$6.6
- Canada = \$6.2
- United Kingdom = \$5.6
- France = \$5.3
- Australia = \$4.9

Significant Cost and Waste

*AHIP, Ensuring Quality Through Appropriate Use of Diagnostic Imaging, July 2008

- Association of Health Insurance Plans* (AHIP) estimates \$30B per year is "wasted" on advanced imaging
 - 20-50% of advanced diagnostic procedures were unhelpful for diagnosis*
- American College of Radiology estimates 20-30% of advanced imaging studies:
 - Are not the appropriate study
 - Do not add anything to the diagnosis
 - Are repeated too soon



General Cost Considerations

- Risk pools - population risk assessment by actuarial analysis
- Government v Commercial Plans
 - Who establishes premiums? (e.g. PA Medicaid & Anthem BC CA)
- Choice is expensive – plan design and what services are covered
 - Indemnity
 - PPO
 - HMO
- Cost of care
 - Utilization
 - Unit cost
- Access, Cost/Efficiency, Quality

How Do Payers Attempt to Contain Cost?

- Utilization Management
 - Outreach and education
 - Prior authorization (Acute care/Rx/DME/Rads/Labs)
 - Medical Policy/SOPs/Hayes/UTD/peer reviewed medical literature
 - Nationally Recognized Guidelines (e.g. Milliman, InterQual)
 - Concurrent review (DRG v Per diem)
 - National Guidelines (e.g. Milliman, InterQual)
 - Reconsiderations (P2P reviews)
 - Care Coordination (DM/CM/ICM)
 - Appeals
 - Provider
 - Member
- Unit cost
 - Providers, hospitals, ancillary, radiology, laboratory, home infusion/health care
- Combination

Medical Necessity Determinations

- Milliman Care Guidelines
- InterQual (McKesson) Level of Care Guidelines
- Used to address care in the following settings:
 - IP & Surgical (Adult & Pediatric)
 - Observation
 - Ambulatory
 - Behavioral Health
 - Recovery Facility
 - Home Care
- Medical Policy/Standard Operating Procedures

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Inpatient and Surgical Care

Pneumonia, Community Acquired

ISC - Pneumonia, Community Acquired - ORG: M-282 (05-55-01-0b, M282)
 Inpatient and Surgical Care (ISC) > Thoracic Surgery and Pulmonary Disease> Pneumonia, Community Acquired
Pneumonia, Community Acquired
 ORG: M-282 (ISC)
 HSLM: 05-55-01-0b
 Link to Codes

- Care Planning - Inpatient Admission and Alternatives
 - Clinical Indications for Admission to Inpatient Care
 - Alternatives to Admission
- Alternative Care Planning
- Hospitalization
 - Optimal Recovery Course
 - Goal Length of Stay - Ambulatory or 2 days
 - Extended Stay
 - Hospital Care Planning
- Discharge
 - Discharge Planning
 - Discharge Destination
- Usual
 - Alternate
- Quality Measures
- Supplemental Tables
- Pneumonia Severity Index (PSI)
- Annotated Bibliography
- References
- Footnotes
- Codes
- Related Guidelines

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Inpatient and Surgical Care
Pneumonia, Community Acquired

Clinical Indications for Admission to Inpatient Care
 Return to top of *Pneumonia, Community Acquired - ISC*

- Admission may be indicated for 1 or more of the following (1)(2)(3)(4)(5):
 - o Hypoxia, indicated by 1 or more of the following:
 - Oxygen saturation less than 90% or PO₂ less than 60 mm Hg (8.0 kPa) while breathing room air
 - Chronic lung disease with significant deterioration from baseline oxygenation
 - o Failure of outpatient therapy, examples include(6):
 - Failure to respond to antibiotic (eg, resistant organism)
 - Adverse effects from medication
 - Complications of pneumonia (eg, empyema)
 - Worsening of comorbid conditions
 - o Inability to receive outpatient or recovery facility diagnosis and therapy, examples include(2)(6):
 - Critical diagnostic testing unavailable
 - Infection control measures unavailable
 - Inability to take or tolerate oral medications
 - o Prior hospitalization within past 7 days
 - Unstable comorbid condition
 - Complicated pleural effusions
 - o Hemodynamic instability or suspected sepsis
 - Moderate- or high-risk category patients (PSI Class IV or V or CURB-65 score [A] of 2 or greater). See Pneumonia Severity Index (PSI).
 - o Intermediate-risk category patients (PSI Class III) who do not improve with initial therapy and observation. See Pneumonia Severity Index (PSI).
 - o Immunocompromised patients [B] at moderate or high risk on the basis of clinical evaluation

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Pneumonia, Community Acquired

Alternatives to Admission

- Alternatives include(1)(3)(4)(5):
 - o Outpatient care in emergency department, rapid treatment site, urgent care center, or medical office
 - History, physical examination, and assessment of risk factors
 - Chest x-ray and laboratory testing
 - Antibiotics and re-evaluation of hemodynamics, oxygenation status, and other parameters
 - Discharge on oral or parenteral antibiotics
 - o Observation . See Pneumonia: Observation Care guideline as appropriate .
 - o Home care (e)
 - Nursing visits for assessment and laboratory work
 - Parenteral antibiotics; respiratory therapy, and oxygen as indicated
 - o Recovery facility (0)
 - Parenteral fluid and medication
 - Respiratory treatment and oxygen
 - Frequent assessment and treatment
 - Management of comorbidities

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Alternative Care Planning
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- Care planning needs for a patient not requiring admission may include:
 - o Diagnostic tests, including(1) :
 - Pre-antibiotic sputum culture and Gram stain
 - Pre-antibiotic blood culture
 - Chest x-ray
 - Arterial blood gases
 - CSC
 - Chemistry panel
 - HIV serology
 - o Treatments and procedures, including:
 - Antibiotics
 - Respiratory therapy
 - o Discharge Planning, as appropriate
 - o Patient, family , and caregiver education, as appropriate. See Pneumonia, Community Acquired : Patient Education.

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Pneumonia, Community Acquired

- o Treatment failure due to resistant or unexpected organism(20)
- Anticipate change in empiric antibiotics and bronchoscopy with lavage or protected brush specimens.
- Expect brief to moderate stay extension.
- o Respiratory failure: expect moderate stay extension.
- o Moderate hyponatremia (serum sodium concentration less than 130 mEq/L (mmOLL)): expect brief stay extension.(21)
- o Comorbid cardiac disease(17)
- Treatment of congestive heart failure or atrial fibrillation may require longer hospital stay.
- Expect brief stay extension.
- o Comorbid chronic obstructive pulmonary disease (COPD)(19)
- COPD is associated with higher mortality, higher rates of ventilator-dependent respiratory failure, and *Pseudomonas* infection.(19)
- Expect moderate stay extension.

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Pneumonia, Community Acquired

Hospital Care Planning
Return to top of *Pneumonia, Community Acquired - ISC*

- Hospital evaluation and care needs may include:
 - o Diagnostic test scheduling and completion, including(1)(22):
 - WBC count
 - Sputum Gram stain, culture
 - Blood culture
 - ABG
 - Chest x-ray
 - Lung ventilation perfusion scan
 - Bronchoscopy
 - Chest CT scan
 - Echocardiogram

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Pneumonia, Community Acquired

Treatment and procedure scheduling and completion, including:

- IV antibiotics and switch to oral antibiotics (J) (M)
- Nebulized bronchodilators
- Incentive spirometry
- Thoracentesis
- Placement of parenteral access line

Consultation, assessment, and other services scheduling and completion, including:

- Pulmonary medicine consultation
- Infectious diseases consultation

- o Monitoring patient's status for deterioration and comorbid conditions (see General Inpatient Monitoring and Assessment Tool); key items include(22)(23)(24):
 - Hemodynamic stability
 - Respiratory status, including oxygenation and need for respiratory therapy
 - Mental status
 - Signs and symptoms of sepsis
 - Nutritional status, including hydration

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Pneumonia, Community Acquired

Quality Measures
 Return to top of *Pneumonia, Community Acquired - ISC*

- Hospital Quality Alliance (HQA) measures include(26):
 - o Blood culture collected before first antibiotic administration
 - o For patients transferred or admitted to the intensive care unit within 24 hours of hospital arrival: blood cultures collected between 24 hours prior to hospital arrival and 24 hours after hospital arrival
 - o Initial antibiotic consistent with current recommendations
 - o Initial antibiotic dose within 4 hours after arrival at hospital
 - o Median time to first dose of antibiotic
 - o Oxygenation assessment within 24 hours before or after arrival at hospital
 - o Influenza vaccination status screening: vaccination if needed
 - o Pneumococcal vaccination status screening : vaccination if needed
 - o Smoking cessation advice and counseling

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Annotated Bibliography
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See Pneumonia, Community Acquired Annotated Bibliography for a discussion of key literature.

Supplemental Tables
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- Pneumonia Severity Index (PSI)

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InterQual Level of Care Criteria 2009
Acute Care Adult Respiratory/Chest
Discharge Screens (At Least Last 12 h) Rule: One ALOC

Long-Term Acute Care, Both: **Other ALOC (G7)**

- Level of care appropriateness, All:
 - Hemodynamic *and* neurologic stability (16,17)
 - Medical practitioner assessment /intervention daily
 - Respiratory therapist interventions >= 3x/24h
 - Skilled nursing services > 6.5h/24h (G117)
 - Treatment precluded in a lower level (1B)
- Skilled treatment, > One: (GU7)
 - Complex respiratory management
 - Weaning trial (GC27)

How Can Payers Ensure and Improve the Quality of Care?

- Quality Management
 - Certification and Measures
 - National Committee for Quality Assurance (NCQA)
 - Healthcare Effectiveness Data and Information Set (HEDIS)
 - Utilization Review Accreditation Commission (URAC)
 - U.S. Agency for Healthcare Research and Quality (AHRQ)
 - The Consumer Assessment of Healthcare Providers and Systems (CAHPS)
 - Audits (internal and external)
 - Performance Improvement Projects (PIP)
 - Pay for Performance (state program)
 - Awards
 - U.S. News and World Report
 - Credentialing

Recommendations on How We Can Improve the U.S. Health Care System

- Provide universal health insurance coverage for all people w/in the U.S. via either a single-payer or pluralistic system model
- Create subscriber incentives to encourage prudent purchasing of services and participation in their health care
- Develop a national health care workforce policy to support, educate and train the right proportion of PCPs and Specialists and restructure our payment methodology to pay for the expanded use of PCPs (e.g. hybrid model of FFS & administrative fee for care coordination – medical home model)
- Redirect federal health care policy to support patient-centered health care that builds on the patient-PCP relationship and financially supports the patient-centered medical home since evidence suggests it has the potential to improve health outcomes, increase efficient use of resources, and reduce health care disparities

Recommendations on How We Can Improve the U.S. Health Care System

- Provide financial incentives for physicians to achieve evidence-based performance standards (e.g. hybrid model)
- Reduce administrative cost and burdens by creating uniform billing and credentialing systems across all payers
- Fund an interoperable health information technology infrastructure to assist physicians in delivering evidence-based patient-centered care
- Encourage public and private investments in all kinds of medical research including comparative effectiveness of different treatments to foster continued innovation and improvements in health care

Some Current Examples in Philadelphia

- Performance based contracting
 - Collaboration w/facilities and providers
 - Shared savings model
- Simplified P4P programs
- Increased front end self-service w/bi-directional information exchange via Navinet for;
 - Eligibility checks
 - Gaps in care (HEDIS, pharmacy, lab, imaging)
 - Patient care summaries
 - Ordering imaging and lab studies
 - Simplified Prior Authorization list
- Live Call
- ARRA collaboration
 - PHIX/HIEs/Use case certifying agent (?)

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